State of Oklahoma
SoonerCare
Tasigna® (Nilotinib) Prior Authorization Form

OKLAHOMA Health Care Authority

SoonerSelect | aetna

Member Name:_________________________ Date of Birth:_____________ Member ID#:______________

Drug Information

Pharmacy billing (NDC:________________________) Start Date (or date of next dose):________________

Dose:___________________________________ Regimen:______________________________

Billing Provider Information

Pharmacy NPI:_________________________ Pharmacy Name:____________________________________

Pharmacy Phone:____________________________ Pharmacy Fax:________________________________

Prescriber Information

Prescriber NPI:_____________________ Prescriber Name:_______________________________________

Prescriber Phone:_______________ Prescriber Fax:___________________ Specialty:_________________

Criteria

For Initial Authorization (Initial approval will be for the duration of 6 months):

1. Please indicate diagnosis and information:
   - ☐ **Philadelphia Chromosome Positive (Ph+) Acute Lymphoblastic Leukemia (ALL)**
     - A. Upfront therapy (including induction and consolidation) in combination with multi-agent chemotherapy or as a single-agent? Yes____ No____
     - B. Maintenance therapy in combination with vincristine and prednisone, with or without methotrexate and mercaptopurine? Yes____ No____
     - C. Maintenance therapy including post-hematopoietic stem cell transplant? Yes____ No____
     - D. For relapsed/refractory disease and used as a single-agent or in combination with multi-agent chemotherapy? Yes____ No____
   - ☐ **Chronic Myeloid Leukemia (CML)**
     - A. Newly diagnosed chronic, accelerated, or blast phase CML? Yes____ No____
     - B. Philadelphia Chromosome Positive (Ph+) CML chronic phase (CP) resistant or intolerant to prior tyrosine-kinase inhibitor (TKI) therapy? Yes____ No____
     - C. Post-hematopoietic stem cell transplant? Yes____ No____
   - ☐ **Soft Tissue Sarcoma – Gastrointestinal Stromal Tumors (GIST)**
     - A. Progressive disease and failure with imatinib, sunitinib, or regorafenib? Yes____ No____
   - ☐ **Other, please provide diagnosis:______________________________**

Additional Information:____

____

For Continued Authorization:

1. Date of last dose:_____________________________
2. Does member have any evidence of progressive disease while on nilotinib? Yes____ No____
3. Has the member experienced adverse drug reactions related to nilotinib therapy? Yes____ No____

*If yes, please specify adverse reactions:*____

Additional Information:____

Prescriber Signature:___________________________________ Date:________________________

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.

Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.	CONFIDENTIALITY NOTICE *This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*